Ethical Considerations When Making Exceptions to "Rules" in Psychiatry

by Edmund Howe, MD, JD

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ABSTRACT

This article explores several contexts in which psychiatrists may face having to decide whether to make exceptions to rules or guidelines when treating their patients. Contexts discussed include paternalistically going against a patient's autonomy, violating professional psychiatric standards of care, and clashing with some kind of institutional policy. The author contends that standard guidelines cannot possibly apply optimally to all patients, and thus there will be times when exceptions to these guidelines must be made by the psychiatrist. In addition to discussing the ethical considerations, the author offers some suggestions when faced with certain conflicting situations.

KEYWORDS

Psychiatric treatment, ethics, exceptions, intimacy, paternalism, autonomy, persuasion, coercion, families, standards of care, advocacy, gifts, couple therapy, gifts, discharging, anti-suicide contracts

INTRODUCTION

Often, in psychotherapy, psychiatrists and other therapists try to help patients cope optimally through externally imposed requirements that the patients may not like (e.g., requiring patients to arrive for their appointments on time). Analogously, psychiatrists may feel inclined to adhere to and apply their usual professional guidelines when treating their patients and may feel generally reluctant to make exceptions to these guidelines. Yet due to their very nature, requirements and guidelines, like moral codes, cannot be optimal for all individuals, and variations on their use can and do arise. In some cases, following guidelines, or the "rules," might even be harmful to the patient.

Posed in theory, the Ten Commandments is an example. While, generally speaking, one should not kill, an exception to this might be warranted when one needs to protect oneself or one's family. All norms may, in fact, be justifiably overridden when there are other norms warranting precedence.

A psychiatric example is how psychiatrists should respond when patients want to give them a hug. Hugging can be intimate and, thus, therapeutically problematic. Yet, if a patient's loved one has just died, it might be fatal to the therapy and even inhumane for the psychiatrist not to return this initiative.

Glen Gabbard, a psychiatrist recognized as an authority on making decisions involving boundaries, states that in certain circumstances, such as when a patient has just lost a child, if the therapist does not return an offered hug, this may "wound" the patient profoundly, and he or she may never return to see the therapist.[1] Even so, as with all treatment exception decisions, the psychiatrist may still feel cognitive uncertainty and anxiety.[2,3] I myself have faced the hugging dilemma a few times over decades of practice and still feel some anxiety when confronted with it.

There are numerous contexts in which treatment dilemmas can arise, and the core clinical and ethical considerations differ for each one. This article will present three paradigmatic contexts where psychiatrists may be forced to choose between doing what they believe is best for an individual patient and following the "rules:" 1) weighing paternalistic interventions against respecting patient autonomy, 2) weighing patient interest against usual psychiatric standards of care, and 3) weighing patient interest against hospital or institution policy. I will also provide some case examples, when appropriate, illustrating the paradigmatic context. I shall suggest that since by the very nature of rules, they cannot take all individual variations into account, there are times when it might be better for the patient if the psychiatrist violates his or her usual standards of care, such as giving a patient a hug. This piece will explore primarily when and how these exceptions might be made.

WEIGHING PATERNALISTIC INTERVENTIONS AGAINST RESPECTING PATIENTS' AUTONOMY

Subtle coercion. One of the most difficult decisions psychiatrists can make is whether to violate competent patients' autonomy.[4-6] This decision, as I am using it here, involves a whole spectrum of interventions in which psychiatrists may use their role to challenge what a patient has already indicated he or she wants. This may involve merely "pressing" a patient more than a psychiatrist generally would in the hope of moving the patient to a different decision. This could be considered a more subtle application of paternalism rather than a more direct challenge to a patient's autonomy, such as hospitalizing a patient involuntarily.

Ethically, it is "supererogatory," or goes beyond what is expected, to take on this subtle type of initiative because one thinks it could benefit a patient. This seeking to do greater good might be morally equal to avoiding harm. Traditionally, the Hippocratic Oath placed greater moral weight on avoiding harm than doing good, but this prima facie presupposition may be no longer warranted.

Case example. A patient underwent a diagnostic test that showed she had cancer. The cancer was caught early, and the patient was told treatment would be likely to cure her; however, she refused to seek treatment.[7] The patient revealed this to her psychiatrist, who then debated whether she should encourage the patient to seek treatment for the cancer, as this would violate the patient's privacy. The psychiatrist ultimately decided to repeatedly encourage the patient to seek treatment. The patient, "harassed" by her psychiatrist in this way, decided to undergo treatment and was cured.

Direct coercion. Many psychiatrists might not try to persuade an unwilling patient to involve family members in his or her care, even if the psychiatrist believes this would enable the patient to do better. Any efforts to do so would be considered mildly coercive. But in some cases, it could be argued that some coercion, and thus some paternalism, would clinically be both indicated and ideal.[9] Some psychiatrists, however, practice in contexts where they take coercion further. They might refuse to treat a patient unless the patient agrees to involve his or her family. Should they do this?

Case example. A young man, diagnosed with schizophrenia, tried to kill himself by taking three bottles of pills. After the suicide attempt, his mother began regularly checking his Facebook page to see if he was making posts on biblical arcana, which she recognized as a warning sign of an impending breakdown. She also carefully monitored his behavior at home: "She watches little things, such as whether he dries off with a towel after a shower or walks naked and dripping to his bed…whether he remembers to put on deodorant, how he eats…."[8] She was diligent in monitoring him because he had told her if he "ever decided to commit suicide again," he would "make sure that no one suspected it."[8]

As in the young man's case above, family members may be able to detect when the patient is becoming ill before the patient can. Thus, the family member(s) can be an ally to both the patient and the psychiatrist. It is in the patient's best interest for the psychiatrist to explain to the patient why his or her family member(s) should be involved in his or her care, so that the patient is at least maximally informed.[10]

If a psychiatrist does take the position of not treating a patient unless the patient is willing to include family members in the treatment, this judgment may, in part, enable the psychiatrist to feel less vulnerable. Without the family's help, a psychiatrist may feel he or she is trying to treat a patient with "one hand tied behind the back."

Psychiatrists may gain sufficient relief from potential conflicting feelings over whether to use coercion by consulting with colleagues. They should not worry alone.[11,12] Still, if a psychiatrist feels too afraid to resolve this conflict over treatment, notwithstanding colleagues' support, this feeling may result in the psychiatrist unconsciously or consciously resenting the patient, and thus the psychiatrist may not be able to treat the patient as well.

Another consideration is that a psychiatrist who feels fear over treating a patient without the involvement of the patient's family might respond to the fear by requiring that the family be involved, and this may make the psychiatrist feel guilty as well. In other words, the psychiatrist might believe that if he or she insists on the patient involving family members in the treatment, this may be serving the psychiatrist's needs more than the patient's. One cannot validly know, however, how much one is truly seeking to meet one's own needs as opposed to one's patient's. It very well could be that a psychiatrist who refuses to treat a patient without the involvement of family members is doing this for his or her own sake. But that possibility does not make it a fact across the board.

We psychiatrists are all susceptible to regarding correlations as causally related, regardless of our best efforts not to, and in this type of situation, that is a risk. However, when a psychiatrist chooses to make a paternalistic exception or an analogous decision posing this same risk, the psychiatrist should assure him- or herself that while what he or she fears might be the driving factor behind the decision, more likely it is not.

WEIGHING PATIENT INTEREST AGAINST USUAL PSYCHIATRIC STANDARDS OF CARE

Psychiatrists take most psychiatric treatment guidelines, which are likely evidence-based, as sound rules of thumb. As mentioned before, however, rules cannot by their very nature apply optimally to all situations.

Following are three examples of treatment violations of guidelines or rules in psychiatry: 1) seeing patients both individually and in couples therapy, 2) advocating for a patient while concomitantly treating the patient in psychotherapy, and 3) accepting gifts from patients.

Seeing patients both individually and in couples therapy. Seeing patients both individually and in couples therapy may cause certain problems.[13,14] For example, the psychiatrist may not be able to fully explore how a patient feels toward his or her partner because, since the patient is aware that the psychiatrist is also seeing the partner, the patient, consciously or unconsciously, may want to protect the partner from the truth and thus may not be completely honest. Likewise, the psychiatrist may also under these conditions acquire information that he or she does not believe should be shared with the partner,[15] and this need for concealment, or "deceit by omission," may be emotionally taxing.

Though some may regard "deceit by omission" as not true deceit, it is. To see ethical conflicts clearly, harms must be "labelled" as what they are. Keeping this in mind will clarify that, in many instances, some degree of deceit may be morally "right." Times may arise in which a psychiatrist seeing two patients individually and as a couple is best for both patients.[16,17] A psychiatrist, for example, may know one patient very well, and this "foreknowledge" may enable the psychiatrist to help both partners in ways that, otherwise, no one could. In this event, the psychiatrist should show respect for both patients by discussing with them the pros and cons of treating both of them beforehand.

Case example. A woman had been in psychotherapy for many years and through some particularly tragic events. She later got married and asked her psychiatrist to see her husband and her together as a couple, while continuing her individual therapy. The psychiatrist, believing his knowledge and understanding of the woman after years of therapy might benefit the pair, agreed to couples therapy.

During couples therapy, the husband revealed that he was afraid to share some important things with his wife because he did not think she would forgive him and thus this might end the marriage. The psychiatrist counseled the husband that he believed, based on the many years he had been treating the woman, that she would take what the husband wanted to tell her "in stride." The husband then shared what he needed to with his wife and they thrived as a couple. The psychiatrists could have been wrong about the woman's reaction to the husband's news, but this may be a risk that was worth taking.

Advocating for a patient while concomitantly treating the patient in psychotherapy. A common guideline in psychiatric practice is not to be a patient's therapist and advocate at the same time.[18,19] Why? The core concern is that this dual role may undermine successful therapy. The patient may know, consciously or unconsciously, that a need for the psychiatrist to be his or her advocate may arise. This may create a bias in the patient during therapy in order to benefit from this "anticipated" secondary gain, and thus therapy is no longer "genuine."

There may, however, be some contexts in which advocating for a patient that a psychiatrist is currently treating is justified.[20,21] One example is when the treating psychiatrist is the only one who knows the patient well enough to be able to say, as in court, what is most likely to be the truth.

Case example. A middle-aged man was seeing a therapist for

depression and revealed that he was about to be fired from his job for being too lethargic to carry out his duties. The therapist, advocating on the patient's behalf, informed the employer of the patient's depression, and the patient was able to keep his job. With treatment, the patient did overcome his depression, and the employer told the patient that he was the best worker he had.

This example shows how a traditional approach to ethics, based on abstract moral principles, may be best balanced with a newer approach, called the "care perspective." This approach takes more into account patients' feelings and "the actual consequences of a decision for the involved parties, how the decision would affect the relationship, the context, the need to avoid hurt, and issues of altruism."[22]

In one study, testing the degree to which both individual and family therapists engaged in this balancing, the researchers found that both kinds of therapists emphasized meeting the "client/family's needs and maintaining the relationship with the client." These authors comment, "This would indicate that practicing therapists, *regardless of theoretical orientation*, have adopted a model of decision making that focuses on values identified with an ethic of care"[22] (emphasis added). This balancing may support making this exception in these kind of cases.

Accepting gifts from patients. The prevailing consensus regarding accepting gifts from patients is that to do so may "stretch therapeutic boundaries."[23] Most psychiatrists regard the act of gift giving from patients as an acting out of transference feelings. Thus, most have deemed it important to discuss the motivations behind the gift giving with the patient and possibly to not accept the gift.[23]

Because some patients may see this as a rejection, some psychiatrists have gone so far as to tell their patients at the beginning of psychotherapy that they will not accept gifts. They note, however, that the price of stating this policy may be losing "potentially fruitful discussions" based on the meaning gift-giving has for these patients.[23]

Exceptions may be warranted when adolescents and children give gifts, since they may be both more sensitive to rejection and less able to work "through" these feelings.[23] Cultural exceptions also may be warranted. For example, in Asian culture, refusing to accept a patient's gift may be construed as an insult.[23] Additional considerations may be warranted for patients during particularly problematic times and early on in therapy.[23] In any context, the psychiatrist should consider if accepting a patient's gift could help equalize the therapy relationship,[23] because this in turn may help the patient become more active in therapy and be better able to pursue his or her therapeutic needs.[24]

Case example. A psychiatrist rejected a Christmas gift from a patient who was a therapist. The psychiatrist reasoned that he should do this in this particular case because the patient was in the same profession as himself. The patient was very distraught that the psychiatrist did not accept the gift. The psychiatrist subsequently spent many weeks attempting to undo the harm caused to the therapeutic relationship by not accepting the gift. Eventually, therapeutic trust was restored to the relationship, but the psychiatrist regrets not accepting that gift to this day.[25]

WEIGHING PATIENT INTEREST AGAINST DEPARTMENT, HOSPITAL, AND INSTITUTIONAL REQUIREMENTS/POLICIES

Different psychiatric departments, hospitals, and institutions have different rules. Each facility tries to minimize risks to their patients, but, like standards of care, sometimes the rules do not optimally apply to individual patients.[26] At times, the psychiatrist must decide to do what is best for the patient he or she is treating even if this means going against the rules of the treatment facility.

Discharging patients over weekends. Hospitals notoriously experience a higher number of quality control problems over weekends than other days of the week, primarily because there is less staff on hand. I recall one of my own family members spending hours on the phone with hospital staff one weekend in an unsuccessful attempt to find a doctor with sufficient expertise to treat her husband, who was experiencing a life-threatening crisis. To avoid the quality control risk that understaffing can pose to patients, many hospitals have policies in place to either try to discharge patients prior to the weekend or not allow patients to be discharged over a weekend. Either situation may not be in an individual patient's best interest.

Ethically, this situation illustrates the so-called utilitarian principle, which holds that a rule designed to benefit the most people in net effect may be justifiable, though it can be anticipated that following this rule will cause some individuals harm. What then should a psychiatrist do when faced with a patient for whom a weekend discharge is clinically indicated but hospital policy will not allow it?

First, the psychiatrist could immediately appeal within the

hospital structure to bend the rule regarding discharge for his or her patient, and, if this is unsuccessful, later appeal to the hospital to institute an on-going mechanism within the discharge policies that allows, in certain cases, for patients to be discharged during the weekend.

Second, the psychiatrist could tell the patient three things: 1) how the utilitarian principle works and that, in the patient's case, this principle is causing harm; 2) that the psychiatrist will immediately appeal to the hospital administration in an attempt to get them to bend the rule regarding weekend discharge for his or her patient; and 3) that if the immediate appeal is denied, the psychiatrist will later appeal to the hospital administration to institute an on-going mechanism within the discharge policies that allows, in certain cases, patients to be discharged during the weekend. If the latter is the case, this will not solve the patient's immediate problem regarding discharge, but at the very least it will validate the patient's angst and help preserve the patient/psychiatrist bond by helping the patient to feel less alone.

In certain situations, the psychiatrist may want to maximally warrant and retain the patient's trust by taking the route that will most likely achieve this. Thus, if the psychiatrist believes it is in the patient's best interest to be discharged over the weekend and that this action will most likely retain the patient's trust, the psychiatrist should consider being willing to do this. Giving ethical priority to the patient's best interest might be regarded as the "high road," and as ethically "praiseworthy," though not necessarily morally obligatory. This is because this choice would fulfill what the psychiatrist sees as the patient's best interest, even though there is risk to the psychiatrist for violating his or her conditions of employment.

The ethical question then may arise as to whether the psychiatrist should sign out the patient "against medical advice" or "AMA."[27] The highest ethical road might be to not indicate AMA on the discharge since this may be considered, by the patient, as "siding with the institution," as opposed to supporting the patient fully. This could also pose a risk to the psychiatrist; thus, a note in the chart indicating the rationale behind the weekend discharge may be advisable.

Asking patients to sign anti-suicide contracts. Asking a patient to sign an anti-suicide contract may either work against the psychiatrist and his or her patient or may be clinically and ethically optimal for the psychiatrist and his or her patient.[28,29] Though there is insufficient evidence at this time on whether asking patients to sign anti-suicide contracts is optimal or harmful for patients,[28,29] the ethically preferable choice at this time might be to not ask them to sign anti-suicide contracts. This choice would give ethical priority to maintaining maximal patient-psychiatrist trust. Again, as a protection measure for the psychiatrist, he or she should consider putting a note explaining this rationale in patient charts.

According to Edwards and Harries, anti-suicide contracts have developed over the past four decades, and the authors report, "...a fourth shift occurred when practitioners began to use these clinical interventions for self-protection [from litigation]—attempting to mitigate the demands of an over-stretched service environment…"[29]

Many psychiatric facilities formally or informally now require their providers to request that patients sign anti-suicide contracts and then to take greater precautions if a patient refuses. The belief behind the contract is that if a patient signs a contract promising he or she will not commit suicide, he or she may be less likely to actually do so.

Some patients, however, may balk at being asked to sign such a contract. Perhaps these patients believe it is a breach of trust for their psychiatrists to request this.[30] Or perhaps these patients believe that such a request demonstrates a lack of understanding toward them by their psychiatrists or a lack of desire to understand them. These beliefs may stem from the fear that they may not be able to fight a sudden urge to attempt suicide. If this is the case, the best the psychiatrist may be able to do is acknowledge with the patient this fearful possibility so that the patient does not feel alone. The psychiatrist may also consider acknowledging these issues with a colleague so that the psychiatrist does not feel alone.

When faced with a suicidal patient, the psychiatrist might first consider discussing the pros and cons of being asked to sign an anti-suicide contract with the patient before actually requesting the patient do so. The discussion could include the fear of the patient losing trust in the psychiatrist, the fear of the patient sharing with the psychiatrist that he or she may not be able to fight the sudden urge to attempt suicide, and the hope that by being asked to sign the contract, the patient will feel less alone. The psychiatrist may also consider discussing with the patient that asking patients to sign anti-suicide contracts is a requirement of the hospital in which the psychiatrist works and that the patient can refuse to sign one if he or she wishes. Hopefully, openly acknowledging these issues with the patient will

mitigate damages to the therapeutic relationship.

CONCLUSION

Psychiatrists may encounter a host of conflicting situations where they will be forced to choose between doing what they believe is best for an individual patient and following the "rules." Making exceptions to the rules may mean paternalistically going against a patient's autonomy, violating professional psychiatric standards of care, or clashing with some kind of institutional policy. Psychiatrists must carefully weigh the pros and cons in each situation but the goal should almost always be that optimal care is provided for patient.

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AUTHOR AFFILIATION: Dr. Howe is Professor, Department of Psychiatry, Director, Programs in Medical Ethics, and Senior Scientist, Center for the Study of Traumatic Stress, Uniformed Services University of the Health Sciences, Bethesda, Maryland.

ADDRESS CORRESPONDENCE TO: Edmund Howe, MD, JD, A1040J, USUHS, 4301 Jones Bridge Rd., Bethesda, MD 20814-4799; E-mail: edmund.howe@usuhs.edu